proud past, promising future
CLARK COUNTY
WASHINGTON

Children's Respite Services Request

Date: _____

Last Name: _____ First Name: _____ MI: _____

Consumer Case ID: _____ Date of Birth: _____

SSN: _____ Medicaid PIC Code: _____

Current Mental Health Agency: _____

Therapist/Case Manager: _____

Please send updated treatment plan with this form, with the inclusion of respite services and signed by the consumer and/or parent or legal guardian.

Person(s) making the request for services: _____

Relationship to Child: _____

Clinical Justification (*Describe child and family need for respite services*):

_____

_____

_____

_____

Schedule (*day(s) of the week and times*): _____

_____

Anticipated start date of respite services: _____ Anticipated total # of respite hours: _____

Please fax to (360) 397-2490 Attn: Care Manager

For RSN use only:

Date Received at RSN: _____ RSN Care Manager: _____

Approved/Denied: _____ Reason if denied in full or part: _____

_____

_____